PRIMARY CARE: DELIVERING THE FUTURE

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FOREWORD

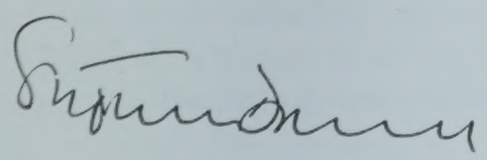
The Government is committed to build on the achievements of the National Health Service. In the White Paper *The NHS: A Service with Ambitions*, published last month, we set out our ambition for "a high-quality, integrated health service which is organised and run around the health needs of individual patients...an NHS which, where appropriate, brings services to people, balancing, for each individual, the desire to provide care at home or in the local community with the need to provide care which is safe, high quality and cost effective".

The development of primary care is central to the realisation of this ambition. That is why we launched last year a wide-ranging debate about the future of primary care. We have listened carefully to that debate. And we have always made clear our commitment to respond positively, with clear proposals to improve primary care.

The White *Paper Primary Care: The Future - Choice and Opportunity* was the first part of our response. It responded directly to calls - not least from primary care professionals - for greater local flexibility in the use of resources so that services can be better tailored to the needs of people and the aspirations of those who work in primary care. It set out proposals for legislation to bring this about. The NHS (Primary Care) Bill currently being considered in Parliament will provide the means and opportunities for innovation and improvement in primary care services.

This White Paper is another vital part of the Government's response to the primary care debate. It sets out a series of practical proposals for action to complement the opportunities offered by the legislation. The proposals reflect many excellent and constructive contributions made during the debate on the future of primary care. It also sets out the details of the significant increases in resources which the Government has made available to help Health Authorities and health professionals to develop primary care both through the existing mechanisms and by taking advantage of new flexibilities and initiatives.

Together with the proposed new legislation, this White Paper sets out an agenda for primary care into the next millenium.



Rt Hon Stephen Dorrell MP
Secretary of State for Health

Chapter 1

PRIMARY CARE : DELIVERING THE FUTURE

1.1 Primary care is fundamental to the National Health Service. It is most people's main point of contact with the service. High quality and strong primary care services are essential to delivering effective and efficient health care.

1.2 Primary care has developed rapidly in recent years. Advances in medical knowledge backed up by new technologies, larger teams of dedicated staff bringing new skills to primary care, and increasing investment have raised both the quality and the range of services provided. At the same time, many primary health care teams have taken on a wider role in the provision, planning and management of services through GP fundholding and GP-led commissioning. But these changes and opportunities have also brought pressures on the service. Changes in the workforce, including the expectations and aspirations of those involved, have contributed to these pressures. And, although services have generally improved, the effect has been patchy. Some parts of the country and some groups of people continue to be less well served than others.

1.3 It is clear that we stand at a significant point in the development of primary care. The Government's White Paper *The NHS: A Service with Ambitions*, published in November 1996, set out an ambition for a high-quality, integrated health service, responsive to the needs and wishes of patients and carers. It described the pivotal role that primary care has and will develop in the NHS of the future, co-ordinating the care of patients as they travel through the NHS, providing skilled advice, treatment, health promotion and care in partnership with other professionals and agencies, and adapting and responding to the needs of local communities.

1.4 There has been an extensive debate over the last year about the future development of primary care. Some important principles based on the touchstones of quality, fairness, accessibility, responsiveness and efficiency set out in *Primary Care: The Future* have emerged from that debate against which current services and future developments can be tested. A number of the key themes to emerge are also strongly reflected in *The NHS: A Service with Ambitions,* including:

- flexibility to respond to differing needs and circumstances;
- the importance of professional development and teamworking;

- the increasing role of information and information technology;
- knowledge-based decision-making; and
- the need to manage "seamlessly" across organizational boundaries.

1.5 Against this background, there has been general consensus about how primary care might develop, the problems to be tackled and the approaches which might be adopted. The emerging areas for action have also been endorsed. Many interesting and positive ideas about how services, structures and organisations might be improved have also been put forward. The task is now to move from debate to action. This document sets a clear agenda.

1.6 Our aim is to enable local people to shape and develop high quality primary health care services in a way which makes best use of the resources available and best suits local circumstances and needs.

1.7 This agenda does not require immediate radical change. Primary care is already in excellent shape in many places. The agenda set out here is essentially evolutionary. But it will provide the means for extensive development and improvement if the opportunities it presents are taken up locally.

1.8 Primary care depends on the contribution of a wide range of professionals working together to meet the needs of all patients living in the community. At its heart is the family doctor and the general practice team of nurses, managers and, increasingly, other professionals. They need to work closely with community nurses, midwives, and therapists to offer comprehensive and appropriate support to their patients. But primary care does not stop here - pharmacists, dentists, and optometrists on the high street provide essential services as, for example, do social workers and housing officers from local authorities. The proposals in this document should enable all of these to play their part better, to extend their role where appropriate and to ensure that services are co-ordinated around the needs of individuals.

1.9 To achieve this, the skills and knowledge of primary care professionals need to be further reinforced to ensure that the care which they deliver is always of a high quality. And the premises which they work from should meet the needs of modern health care.

1.10 Information technology has the potential to revolutionise health care in the next decade. We must exploit the opportunities. It can underpin better team-working. It can give access to unrivalled knowledge at the press of a button. It can support collaboration and co-ordination among health professionals.

1.11 Such an approach would enable:

- consistently high quality primary care across the whole of the country and for all patient groups;

- a wider range of services to be provided closer to home;

and give

- greater scope for personal and professional development and career opportunities for GPs and the professions working with them.

1.12 The most vulnerable people in society, for example people in nursing homes or mentally ill people, need the care, attention and support of many professionals working in the community. GPs, community nurses, therapists, social workers, pharmacists, housing officers all have essential parts to play. But to be most effective they need to know what they can expect from their colleagues, and they should be able to work together to meet the needs of individual patients. Our aim will be to remove barriers to such collaboration and make systems more flexible.

1.13 Patient involvement and choice must be strengthened. The Government is supporting local action in this area through the Patient Partnership Strategy. Primary care has an important part to play here. In doing so, those who work in the service must recognise not only the right of patients (and, if patients agree, carers) to be properly informed about the quality of service which they can expect and to be involved in decisions about care and services. But the public must also recognise their responsibilities towards the service and their own health. It is estimated that ninety per cent of episodes of ill health are treated without recourse to the NHS. Even a minor change in that figure would have very significant implications for primary care and the NHS in general.

1.14 The proposals outlined in the following chapters represent a programme for action both nationally and locally into the next century. It is not a new agenda. It builds on the changes of recent years by giving those closest to the patient - in this case primary care professionals and their teams - a powerful role in improving services.

1.15 At the same time, Health Authorities will continue to play an important part. They already have responsibility for developing the NHS locally through strengthening primary care, encouraging increased partnership between the various sectors and professionals, involving the public, ensuring equity in the use of resources, making use of clinical effectiveness material in their purchasing decisions and contributing to the education and training of staff working in the NHS through, for example, local consortia.

And many of the points highlighted in this document are already occuring in some parts of the country. The task is to spread such good practice more widely. However, to do that effectively, Health Authorities must work in partnership with primary care professionals, and NHS Trusts and others. They must also develop a local strategy which embraces the policies identified above, brings together individual initiatives and makes best use of the range of mechanisms and approaches open to them.

1.16 This White Paper provides some of the means to do that as well as pointing the way forward on how a Primary Care Led NHS can be realised. It does not set a prescriptive agenda from the centre. The main purpose is to provide Health Authorities and primary care professionals with additional incentives and opportunities. It increases the range of options available locally. How these are taken up is best determined locally in the light of local needs and circumstances.

1.17 Running throughout is a theme of local flexibility. The White Paper *Primary Care: The Future - Choice and Opportunity,* published in October, and the NHS (Primary Care) Bill currently being considered in Parliament directly address this theme. They are an important part of the picture. Together with the proposals set out here they should provide the means, opportunities and incentives to pursue the policy aims and themes which have already been widely endorsed.

1.18 To deliver the vision will also require making best use of the available resources both for the NHS as a whole, and within primary care itself. The Government has made clear in the White Paper *A Service with Ambitions* that it remains committed to real terms increases in NHS spending year by year.

1.19 There has been a significant growth in resources for Health Authorities to develop primary care. The Government believes that primary care should get a fair share of future increases in NHS resources. In 1997/98, the Government will make available an extra £65 million in General Medical Services cash-limited funds (6.7% real terms growth). With these extra resources Health Authorities will be able to develop primary care through the existing mechanisms and take advantage of the additional flexibilities and initiatives in this White Paper.

1.20 The Government has also identified £32 million of growth funds for Hospital and Community Health Services to improve services which lie at the boundary between primary and secondary care. These extra funds are intended to support improvements particularly in specialist support for nursing and residential home care of the elderly, mental health and drug misuse services.

1.21 In addition, the Government aims to increase the proportion of the available NHS R&D budget spent on primary care from an estimated 6-7% of the budget (about £25 million) to some 14-15% (£50 million) over the next five years - subject to the relevance and quality of research projects. This will be discussed with the University sector, other R&D funders and the professions whose commitment is required to deliver this change.

1.22 Finally, in order to help Health Authorities seize the opportunities presented, the Government is creating a £2 million development fund to facilitate implementation of new initiatives locally in line with the proposals in this White Paper.

PRINCIPLES OF GOOD PRIMARY CARE

QUALITY

- Professionals should be knowledgeable about the conditions that present in primary care and skilled in their treatment and in contributing to their prevention
- Professionals should be knowledgeable about the people to whom they are offering services
- Services should be co-ordinated with professionals aware of each others' contributions (including inter-professional working) and no service gaps
- Premises and facilities should be of good standard and fit for their purposes, and equipment should be up to date, well maintained and safe to use

FAIRNESS

- Services should not vary widely in range or quality in different parts of the country
- Primary care should receive an appropriate share of overall NHS resources

ACCESSIBILITY

- Services should be reasonably accessible when clinically needed
- Necessary services should be accessible to people regardless of age, sex, ethnicity, disability or health status

RESPONSIVENESS

- Services should reflect the needs and preferences of the individuals using them
- Services should reflect the health demographic and social needs of the area they serve

EFFICIENCY

- Primary care services should be based on evidence of clinical effectiveness
- Primary care resources should be used efficiently

Chapter 2

DEVELOPING PARTNERSHIPS IN CARE

Introduction

2.1 A seamless service is one of the key objectives set out in *The NHS: A Service with Ambitions*. Patients' needs do not recognise organisational boundaries. For primary care this point has particular relevance. Primary care is most people's point of entry into other forms of health care. It is at the hub of a complex network of services involving day-to-day contact between many different people working within and across primary, secondary and social care boundaries. Partnership between these groups is essential to ensure that sensible boundaries of responsibility do not become barriers to care.

2.2 Those working in primary care already make a major contribution towards ensuring that patients receive seamless care. As the service develops, the need for improved team-working and partnership will grow. Three main areas for action have emerged with particular relevance for primary care:

- better team working within primary health care;
- developing professional roles; and
- partnerships with Health Authorities, secondary care and local authorities.

2.3 This chapter considers how partnership can be developed in these areas. Partnership with patients and carers is considered separately in Chapter 4.

2.4 There is a role for Government in promoting partnerships in primary care. The NHS (Primary Care) Bill has the potential to remove many of the obstacles in the way of effective joint working. Many of the proposals set out elsewhere in this White Paper - for education and training, workforce, premises and better organisation - should also help, as will the work on professional development arising from *The NHS: A Service with Ambitions*. But much also rests on local action and the attitudes and willingness to co-operate between different professional groups and different agencies.

Team working within primary care

2.5 Teamworking within primary care is now well established. Teams of GPs, practice nurses, district nurses, midwives and health visitors are now common throughout the country. The contribution of professions allied to medicine, management and administrative staff is more and more important to these teams. Specialist nurses are also increasingly working with primary care teams providing not only expert advice and care, but also education and training for all clinical staff.

2.6 These teams play an essential role in identifying health need, planning, co-ordinating and delivering care. They enable a more integrated and effective approach to managing and improving service quality, for example through the setting of quality standards which reflect all aspects of care and joint approaches to service monitoring.

2.7 A range of innovative local developments in team working are taking place. For example:

- some primary health care teams now have a mental health professional working with them, providing direct services to primary care patients and also fulfilling a liaison role between primary care and community mental health care professionals;

- the Department of Health has supported 17 pilot projects to test the value of closer working between community pharmacists and GPs on prescribing issues such as formulary development and medication review. Such collaboration offers potential for reduced drug costs, better control of medicines and improved patient care;

- optometrists are collaborating with GPs and hospital ophthalmologists to monitor the eye health of diabetic patients;

- some primary health care teams have introduced methods of clinical supervision and support which cross professional boundaries.

2.8 Health Authorities can provide valuable support to encourage co-ordinated care of this sort. For example, dedicated support staff or funds can help primary health care teams to plan, organize and audit shared care. Support might also include specific training events for primary care teams. Investment in IT developments - for example, shared databases and electronic messaging - should also enable better team working.

2.9 The proposed primary care legislation should, subject to Parliament, create new opportunities to develop team working. Possibilities would include contracts based on practices not just GPs. This would allow a more flexible use of resources which would provide increased

opportunities for multi-disciplinary working and the use of skill mix between GPs, nurses, therapists, managers and others. Health Authorities would have additional scope to enter into local contracts for community pharmacy, optometry and dental services. The sorts of arrangements in paragraph 2.7 could form part of locally agreed contracts.

2.10 The principle of the dental team is also now well established, each member of the team contributing to the skill mix in appropriate ways and with interchangeability of staff. The Government wants to build on this by allowing dentists to manage their practices more effectively, to provide more professional opportunities for hygienists and other dental auxiliaries and to increase the amount of care available for patients. The Government intends to publish for consultation proposals to amend the Dentists Act. The aim will be to enable suitable pilots to take place to evaluate the possible skill mixes and to bring forward developments in a structured way. Initially such pilots are likely to include orthodontic auxiliaries and clinical dental technicians.

Extending Professional Roles

2.11 Primary care professionals in many parts of the country - including community nurses, health visitors, midwives, practice nurses, community pharmacists, optometrists, and therapists - have extended their traditional roles, for example, to improve the range of services available to patients or to take on some of the care provided by doctors. Many GPs have helped in making these changes. This, too, is an area where Health Authorities can facilitate developments locally. In partnership with professionals and NHS Trusts they can promote the development of local protocols for shared care and identify relevant training and education needs.

2.12 The Government believes central action is also needed to explore the scope for further developments in this area. A strong theme from the primary care debate was that many non-medical professionals considered that the current restrictions on prescribing, administration and supply of medicines limited unreasonably the services which they could offer to patients. In response to this, the Government proposes to take action now in two areas.

2.13 *First*, the Government intends to roll-out the existing nurse prescribing scheme, in the first instance to a further seven NHS Trusts in each of the remaining Regions with a view to full implementation from 1 April 1998. As a result, some 500 practices and 1,500 nurses will be involved in piloting the new arrangements. There will then be a valuable nucleus of expertise in each Region to draw on in the course of full implementation.

2.14 *Second*, the Government intends to set up a professional working party, to undertake a review over a 12 month period of the prescribing and supply of medicines. The purpose of the review will be:

- to develop a consistent framework to determine in what circumstances health professionals could undertake new roles with regard to the prescribing or supply of medicines, in the course of their clinical practice;

- to consider the implications for legislation and for professional training.

The overriding principle will be that any changes to existing roles must at the very least maintain if not enhance patient safety. The changes would also need to be cost-effective and bring demonstrable benefits in terms of patient care and make better use of the professional skills available. The terms of reference for this review will be discussed with the relevant professional organisations.

2.15 A range of other action is under way or planned.

2.16 For nursing, the UK Health Departments, professional organizations and statutory bodies are assessing the implications of the development of nursing, midwifery and health visiting roles - and the implications for education, training and research - in the light of major changes taking place in professional practice. They are developing a clearer view of roles and responsibilities for these professions.

2.17 In community pharmacy, there are many examples of GPs and pharmacists collaborating on issues of GP prescribing policy - for example, making use of pharmacists' particular knowledge of drug products to develop formularies and to undertake audit projects. In some cases, such joint working is increasingly focused on the individual patient. Evidence suggests that many patients do not get the best use from their medicines. This can lead to both ineffective care and ineffective use of resources. The Government wants to explore the possibility, including care and resource implications, of community pharmacists taking on a broader responsibility for facilitating this. For example, in liaison with prescribers and others, community pharmacists could help to ensure that patients' medication regimes are right for them, that they are taking their medicines appropriately, and that supply is tailored to patients' (or carers') needs. The Government is funding pilot projects to evaluate the enhanced involvement of community pharmacists in several areas, including support to patients in complying with their medication regime, pharmaceutical care for particular patient groups, and repeat and instalment dispensing. The Government will discuss with pharmacists' representatives the role of community pharmacists in helping patients get best use from their medicines.

2.18 The Government also believes that some pressure on general medical services could be relieved by extending local "shared care" agreements - between GPs, hospital ophthalmologists and optometrists - for GP practices to direct patients with eye problems to optometrists and, where appropriate, for optometrists to refer patients direct to the hospital eye service (notifying GPs at the same time). Such arrangements would need to be based on locally agreed protocols involving all the interested parties. The Government will explore with the professions how these arrangements can be evaluated.

Partnerships

2.19 In addition to better multi-disciplinary working within primary care, closer partnership between primary care, secondary care and local authorities (particularly social services) is essential to ensure effective co-ordination of services and their smooth development.

2.20 The NHS is better placed than ever before to achieve such arrangements. The Health Authorities Act 1995 established for the first time a single authority at local level responsible for people's health needs across the full range of health care. A key responsibility of the new Health Authorities is to bring together those in primary and secondary care to develop and implement agreed local health care strategies working in partnership with local authorities and other local agencies.

2.21 Together with GP fundholding, this has already resulted in many collaborative service developments of benefit to patients. Hospital at home schemes, outreach services, mental health and primary care liaison teams, integrated out-of-hours and A & E services and agreed clinical and prescribing protocols to support shared care of patients are all examples of successful collaboration.

2.22 Collaboration between agencies both at a strategic level and at the level of individual care packages is essential in meeting the needs of people with chronic diseases and for older people with complex needs. Groups representing people with chronic conditions have emphasised the need for care co-ordination and management responsibility to be clearly assigned within primary health care teams. The Department of Health working with the Department of the Environment has encouraged innovation in collaborative working through guidance on joint commissioning and training and development support. Further work is in progress to identify good practice in collaborative working across primary and social care boundaries.

2.23 Much progress has been made in developing and implementing policies to deliver comprehensive health and social care services to people with mental illness. But as we gain more experience in delivering these

services concerns have been expressed that there may be particular structural and organisational barriers between the agencies and practitioners involved which are impeding progress and the effective delivery of services to individuals, for example health and social services cannot legally pool resources into one budget. The Department of Health has therefore been identifying, in discussion with local people, the legal or other structural obstacles which can inhibit partnership working and what the options for change might be. The Government will shortly be publishing a Green Paper setting out a number of options for discussion on how joint working in mental health services might be improved. The Green Paper will seek views on which options for change would be most supported and utilised by those working in primary, secondary and social care, including the creation of a single agency and shared budgets.

2.24 It is important that the health service contribution to joint working with other agencies, notably social services, should be clearly set out. For example, Health Authorities have for some years ensured that the services they are responsible for are properly covered in community care plans and in the community care charters that local authorities are responsible for publishing. Equally important will be the health service contribution to Children's Services Plans which the Government increasingly looks to as a means of ensuring comprehensive and properly co-ordinated local services for children. The contribution of primary care professionals to these joint working arrangements is essential. The Government looks to Health Authorities to help ensure this happens. This means ensuring that there is effective consultation with primary care professionals about the co-ordination of services across the NHS and other agencies and that their views are taken into account in developing and implementing plans.

Conclusion

2.25 It is clear that opportunities already exist to strengthen teamworking within primary care and across primary, secondary and social care. The Government wants to enhance these opportunities. The measures set out in this chapter will help to do that. But they should not be seen in isolation. The proposed legislation will remove many of the barriers in the way of effective teamworking. The work programme on professional development stemming from the *White Paper A Service with Ambitions* will also encourage multidisciplinary working. Many of the proposals in the rest of this document will also promote more effective partnerships.

DEVELOPING PARTNERSHIPS IN CARE

Summary of proposals

- New employment and contract options in the NHS (Primary Care) Bill to allow increased opportunities for multi-disciplinary working and use of skill mix (2.9)

- Consultation on amendments to the Dentists Act which would enable pilots to test alternative skill mixes in dental teams (2.10)

- Extension of the existing nurse prescribing pilot scheme from April 1997 with a view to full implementation from April 1998 (2.13)

- A review of the prescribing and supply of medicines in the course of clinical practice to consider the scope for health professionals to carry out new roles (2.14)

- Support for pharmacists' wider role (2.17)

- A Green Paper, to be published shortly, setting out for consultation options for improving joint working in mental health services (2.23)

Chapter 3

DEVELOPING PROFESSIONAL KNOWLEDGE

Introduction

3.1 Patients should be confident that those working in primary care have the right knowledge and skills to do their job properly. This calls, in turn, for primary care professionals and staff to have access to high quality professional education, training and development.

3.2 This chapter sets out the Government's immediate plans to take forward the agenda in primary care in response to last year's debate and the conclusions reached in *Primary Care: The Future.*

3.3 Many of the actions will complement the wider work now being undertaken following publication of *A Service with Ambitions.* Important themes to emerge from the primary care debate are:

- multidisciplinary working benefits from multi-disciplinary learning. A greater proportion of all education and training should be multidisciplinary;

- the growing importance of primary and community based health care should be reflected in education and training. There should be greater opportunities for more health care professionals to train in the primary and community care setting;

- continuing education should be developed to suit both the needs of primary care staff and the service;

- the research and development (R&D) base in primary care should be strengthened; and

- clinical audit in primary care should be further developed.

3.4 An important underlying theme is the need to secure greater cohesion between research, clinical audit, clinical guidelines and professional education. They should form part of an integrated whole. Taken together, they are powerful instruments for a higher quality and more effective service. The NHS R&D Programme and the Clinical Effectiveness Initiative have helped progress in these areas but there is more to be done. The work programme set out in A *Service with Ambitions* will address how this can be done for the NHS as a whole. The proposals set out below focus on how primary care can help achieve this goal. A major task, both nationally and locally, is to bring

the threads together particularly in relation to general practice so as to get the most out of the resources available and to ensure that health priorities are properly addressed.

Education and Training

3.5 A recurring theme in the primary care debate has been the need to strengthen development opportunities for all the professions and staff who work in primary care. Two general points have emerged:

- *first,* the training needs of primary care professionals, including those in the community services need to be properly assessed and appropriate training provided for them;

- *second*, such a process must cover all staff, including those in GP practices.

3.6 Both these bear on the work of the consortia which have been established to address non-medical education and training issues and the use of the monies levied from Health Authorities for non-medical education and training. Currently such funds are not available for practice staff training. This clearly hinders an integrated approach across primary and secondary care.

3.7 The Government proposes to move to integrated workforce planning across all sectors of the NHS and all professional groups. Health Authorities will play an important role in assessing the workforce needs for general medical services and, as part of this, the development needs of all primary care professionals. For example, in relation to general practice, Health Authorities need to work closely with GPs and primary care teams to identify practice nurses' needs for induction programmes, education and training, professional advice and locum cover and to feed this information into their discussions with local education consortia. The Government considers that, in addition to their current responsibilities, education consortia should also assess and respond to the needs of practice nurses as part of their overall investment plans. To achieve this, the Government proposes to examine the most appropriate way to bring practice nurses within the remit of education consortia and the practicalities of funding their education and training. The aim is to ensure that all consortia should, from April 1998, address the development needs of practice nurses in their investment plans. As part of this, the Government also intends to encourage the development of professional support and mentorship for practice nurses. The NHS Executive will produce examples of good practice to assist Health Authorities and GPs to develop appropriate development programmes.

3.8 For GPs, there is already a range of mechanisms to enable them to attain the clinical knowledge and skills they need to practice well. But there are also a number of commonly accepted areas where improvements could be made. In particular:

- vocational training for GPs is not flexible enough, particularly in terms of opportunity for training in a primary care setting. It also involves no compulsory test of knowledge or competence ("summative assessment") although most trainees pass the RCGP's membership examination which has such tests;

- education and development opportunities could be offered in a more focused way to address the specific training needs of individuals and to ensure improvements in practice;

- the need for arrangements for GPs to remain up-to-date to become more formalised;

- criteria for accrediting GPs to carry out certain specialist medical services - ie the subsidiary medical lists for minor surgery, maternity medical services and child health surveillance - vary between Health Authorities and do not necessarily require professional knowledge to be kept up-to-date. Both imply that the quality of services may vary too;

- clear arrangements need to be in place to help identify inadequate performance by GPs and to ensure effective remedial action is taken.

3.9 The Government intends to take steps to address all these issues and proposes:

- to require GPs to meet minimum standards as a condition of GP vocational national training. Summative assessment, which has already been introduced on a voluntary basis, will be mandatory by September 1997. The profession has led the way already and the Government is committed now to putting in place the appropriate regulatory support;

- to improve the vocational training scheme for GPs to allow those starting constructed schemes after April 1997 to spend a greater proportion of training time in general practice from April 1998;

- to transfer funding for GP vocational training from April 1998 to the Medical and Dental Education Levy (MADEL) so that it can be integrated more fully with arrangements for commissioning postgraduate training and to allow better targeting of education to

meet individual training needs. This will ensure that general practice has a proper place in medical education. These proposals are based on the Report of the Working Group commissioned to consider the implications for general medical practice arising from the report "Hospital Doctors: Training for the Future". They were the subject of extensive consultation and attracted wide support;

- complementary to the *Service with Ambitions* work programme, to carry out a review led by the Chief Medical Officer of educational arrangements, including study breaks, in general practice to ensure that best value is secured out of the resources available and that the links between education and research, audit and clinical effectiveness are strengthened. The Review will also consider how arrangements for continuing professional development in general practice can be tailored to better meet the needs of individual professionals and the service. The Government also considers that this would also be the best place to consider how arrangements for GPs to remain up-to-date can or should become more formalised;

- to consult the profession on the best ways to ensure national criteria for accreditation to the subsidiary medical lists are adopted and that those on the lists remain up-to-date. This will build on work the profession itself has done to develop guidelines for admission to the minor surgery and child health surveillance lists. The Government will consult the profession on the possibility of making it a regulatory requirement to comply with national criteria;

- to encourage the development of local arrangements for supporting doctors whose performance gives cause for concern through the issue of guidance by July 1997 based on existing good practice and consultation with the profession.

3.10 The Government intends to support the development of General Professional Training in the NHS ideally for all dentists after graduation, with an increasing emphasis on continuing professional development. The aim is to produce a new generation of general dental practitioner who has had experience of providing both primary and secondary oral care and has been trained as a team leader.

3.11 The Government will also implement the recommendations in the Chief Dental Officer's report, "UK Specialist Training", to ensure that specialist dental practices can develop in the community. Training will be shorter, better structured, more flexible but at the same time no less demanding and with the same high standards.

3.12 The Government has endorsed the overall goal of the Steering Committee on Pharmacy Postgraduate Education that all pharmacists providing care to NHS patients should participate in lifelong learning. Continuing education for community pharmacists in England has been provided by the Centre for Pharmacy Postgraduate Education since 1991, and its training programmes will continue to respond to the changing needs of community pharmacists. Within their Code of Ethics, all pharmacists are expected to undertake continuing education as part of their professional development. The Government is keen to reopen discussions with the profession on a link between a minimum level of participation in continuing education and the terms of service for community pharmacists in order to secure a visible means of underpinning continued competence to practice. As with existing services such as the provision of advice to residential and nursing homes, completion of appropriate training is likely to continue to be a prerequisite for providers of new pharmaceutical services.

3.13 The Government makes an annual grant to the College of Optometrists for continuing education to meet the training needs of optometrists participating in shared eye care.

Research and Development

3.14 Many participants in the debate on primary care identified developing Research and Development (R&D) and an R&D-oriented culture as important in improving the clinical and cost-effectiveness of services and the skills and status of the professionals who work within it.

3.15 The opportunities for R&D in primary care are considerable. A recent review by the Medical Research Council identified many unanswered questions about the early diagnosis and management of acute illness, the natural history of common diseases and the way in which primary care is delivered. The greater involvement of primary care professionals in R&D will help us answer these questions. Of equal importance, such greater involvement should significantly improve the take up and implementation of the knowledge we already have.

3.16 Despite these opportunities, the current disparity between R&D activity in primary as opposed to secondary care is striking. In medicine, for example, although more than 30% of the workforce are general practioners, only 5-6% of academic appointments are in general practice and not all of those are engaged in R&D.

3.17 The successful development of good quality primary care R&D will depend on creating an environment in which it can flourish as well as on the commitment of those who work in primary care, the wider NHS, the University Sector, other R&D funders and the professions. The

Government considers that three areas need to be addressed to create the right environment: funding arrangements, the R&D base and ensuring that R&D findings are seen as relevant and taken up by professionals in their everyday work.

Funding

3.18 The Government is currently introducing new arrangements called R&D Support Funding for NHS Providers. Full details will be published in the New Year. However, the Government intends that for the first time, primary care practices will have access to R&D funding on the same basis as NHS Trusts. They will also be able to bid for funds jointly with NHS Trusts. The Government expects through this mechanism to make more funding available for practices who are or who have the potential to become active in R&D. It will also encourage other funders to increase their spending on primary care related R&D and will work with Universities to promote a higher profile and firm academic base for primary care R&D.

3.19 Overall, and subject to the commitment of the University sector, other R&D funders and the professions, and the relevance and quality of research projects, the Government aims to double the existing proportions of NHS R&D spending directly related to primary care practice from an estimated 6-7% (about £25 million) to some 14-15% (£50 million) over the next five years.

R&D Base

3.20 As part of the development of R&D in primary care, professionals of all disciplines need increasing opportunities to be involved with R&D. Some steps have already been taken to achieve this. For example, the changes introduced over a year ago to allow GP fundholders to use savings for research and audit will help to achieve this. The Pharmacy Practice Research Enterprise Scheme which the Government established in 1990 has also started to stimulate the development of broader research training within pharmacy. But more needs to be done.

3.21 A significant minority of primary care professionals have the skills and motivation to initiate their own R&D. The Government wishes to encourage such practitioners, and to help train others to join them. The proposals for more flexible contractual arrangements described in the White Paper *Primary Care: The Future - Choice and Opportunity* and referred to in a number of places in this White Paper will help make it easier to combine academic and service careers. The Government will work with Universities to provide academic support to such practices and to make available training opportunities for them and their staff.

3.22 In addition, experience from a number of practice based Research Networks around the country has shown that many primary care professionals are enthusiastic to collaborate with R&D initiated by others. The Government therefore intends to build on existing networks, and ensure that at least one Network, or equivalent organisation, is operating in each NHS Region by 1998. The new R&D Support funding arrangements outlined above will also make it easier for primary care practices to obtain funding to compensate them for the extra costs of collaborating in R&D. This will make it easier to extend Networks and to involve new practices and practitioners.

Take up of R&D

3.23 Generally, the Government believes that more should be done to help all practitioners learn about and use the findings of R&D. In an evidence based health service all primary care professionals need some contact with and understanding of R&D, whether or not they are directly involved in carrying it out.

3.24 This will be achieved through better dissemination of the findings of R&D, and by promoting appreciation of the role and value of R&D through professional training and education. The review of education arrangements set out in paragraph 3.9 will assist in this. NHS Executive Regional Offices will work with the various interested parties to find ways of improving primary care professionals' access to and use of the findings of R&D and also their influence over the future projects. To be of greatest use, R&D will need to be seen by primary care professionals as relevant to their needs and their everyday practice.

3.25 To assist nurses, midwives and health visitors to participate more effectively in R&D and to use its findings, an education resource pack is being developed. The aim is to encourage, through the greater involvement of these professions in research activities, the further development of knowledge-based, clinically and cost-effective practice.

Clinical Effectiveness and Audit

3.26 A significant programme of work is already underway nationally and locally within the NHS to assemble and disseminate information on clinical effectiveness and to seek to ensure that it is used. It embraces all professions and sectors including primary care. The NHS Executive nationally and regionally and Health Authorities locally as well as the professions themselves are encouraging and facilitating such developments.

Specific national initiatives in relation to primary care are:

- development of clinical guidelines with the Royal College of General Practitioners on common problems: asthma, angina and low back pain;

- support for Health Authority medical and pharmaceutical advisers, particularly on prescribing matters through the newly established National Prescribing Centre;

- further development of a system of prior approval for advanced dental treatment based on clinical criteria;

- development of computerised information and decision support, initially in prescribing through the PRODIGY project, (discussed in Chapter 7) and in dentistry through further development of computer assisted learning and decision support programmes;

- financial support for local initiatives aimed at improving clinical effectiveness.

3.27 Further support for the dissemination of clinical effectiveness information will come from:

- the review of continuing professional development set out in paragraph 3.9;

- development with the RCGP of further tools to support implementation of clinical effectiveness information;

- making available relevant information at the time of consultation, possibly through a directory of clinical effectiveness akin and complementary to the British National Formulary.

3.28 Clinical audit has also developed significantly in recent years. The Government intends to continue to encourage such development. It wants to see audit spread across all professions and, where appropriate, undertaken on a multi-professional basis so as to enhance team working. Relevant initiatives here include:

- exclusion of all the costs of audit from any planned savings in Health Authority management costs;

- a study to identify the optimum data requirements for clinical audit in the NHS. The aim of the study is to facilitate models of data collection that identify the extent, quality and value of NHS-funded clinical audit and the resulting benefits to patient care.

- publication of further guidance to primary care clinical audit groups as foreshadowed in Clinical Audit in the NHS: A Position Statement in order to encourage a multi-disciplinary approach and the linking of practices together;

- the introduction in 1995 of Clinical Audit in the General Dental Service following a pilot peer review scheme. Funds will continue to be made available to develop clinical audit in the General Dental Services. The Government is also supporting a National Working Group on Clinical Audit in Community Dental Practice;

- support for the establishment of pharmacy audit facilitators in two Regions and an audit development fellow at the Royal Pharmaceutical Society of Great Britain.

DEVELOPING PROFESSIONAL KNOWLEDGE
Summary of proposals

Education and Training

- Aim to bring practice nurses under remit of education consortia from April 1998 (3.7)
- Professional support and mentorship for practice nurses (3.7)
- "Summative assessment" by September 1997 for those undertaking GP vocational training (3.9)
- Improved GP vocational training scheme (3.9)
- Funding for GP vocational training brought under Medical and Dental Education Levy from April 1998 (3.9)
- A CMO led review of continuing professional development in general practice (3.9)
- Review of accreditation to subsidiary medical lists (3.9)
- Guidance by July 1997 on local arrangements to support under-performing doctors (3.9)
- Development of General Professional Training for dentists (3.10)
- Development of specialist Dental Practices (3.11)
- Underpinning of continuing education for pharmacists to maintain competence and develop skills (3.12)

Research and Development

- New opportunities for primary care practitioners to be involved in R&D (3.15 - 3.25)
- Collaboration between Government, NHS, Universities and Professions to create environment in which primary care R&D can flourish (3.18)
- New funding system for R&D in NHS to give primary care equal access (3.18)
- Aim at least to double NHS R&D spending relevant to primary care over next five years (3.19)
- Extension of research networks or similar organizations to all Regions by 1998 (3.22)
- Support for nurses, midwives and health visitors involvement in R&D (3.25)

Clinical Audit

- Development of clinical guidelines with RCGP on common problems (3.26)
- Support to Health Authorities on prescribing through National Prescribing Centre (3.26)
- Development of prior approval protocols for advanced dental treatment (3.26)
- Development of computerised information and decision support in prescribing (PRODIGY project) and in dentistry (3.26)
- Development of further tools to support implementation of clinical effectiveness information (3.27)
- Costs of audit excluded from planned savings in Health Authority management costs (3.28)
- Development of clinical audit in General Dental Service and Community Dental Practice (3.28)
- Continuing measures to support pharmacist's involvement in audit (3.28)

Chapter 4

PATIENT AND CARER INVOLVEMENT AND CHOICE

4.1 Patient and carer involvement is essential to help people make informed decisions about their own health care. It also helps primary care professionals, Health Authorities and NHS Trusts develop the services which people need and want. At the same time, responsible use of services by patients and carers is needed to ensure that the greatest number of people can benefit from the services available and to reduce unnecessary burdens on NHS staff.

4.2 People are more likely to make informed decisions about their own health care if they have the right information at the right time. This is one of the key themes of the Patient's Charter and the White Paper *A Service with Ambitions*. Good quality information needs to address:

- people's concern about their health;
- what treatments and services are available;
- which are most appropriate for individual needs; and
- how they can be accessed.

It should also tell people:

- how they can use those services effectively and responsibly.

Improving the quality of information

4.3 People want and need information which will tell them about specific conditions and diseases, particularly in relation to chronic conditions. The voluntary sector produces a wide range of such information to help inform those who contact them. Much of this information is very good, up-to-date, and user-friendly. The voluntary sector also provides people with information on appropriate services as well as advising what people can do for themselves to control or improve their condition.

4.4 There is a complementary role for the health service to encourage people to take an informed interest in their own health, and to point to suitable sources of material and support organizations. Many Health Authorities and primary care professionals already do so. Health promotion is an integral part of general medical services and primary

care teams play an important role in encouraging people to adopt healthy lifestyles. For example, research shows that some patients give up smoking on their GP's advice.

4.5 As part of the NHS Executive's research and development project on computerised decision support (the PRODIGY initiative referred to in Chapter 7), GPs will be able to provide patients with up-to-date personalised information on their condition, treatment options and support networks as part of their consultation. Similar local developments are also taking place.

4.6 A good deal has already been done to improve public information about availability of NHS services in primary care.

4.7 All medical and dental practices now produce practice leaflets about their services. The great majority of GP practices and an increasing number of dental practices also have in place practice charters telling patients what they can expect from their surgery or health centre. Typically, this information includes how to register, surgery arrangements and hours of availability, maximum waiting times for appointments, arrangements for getting test results and repeat prescriptions and how to make suggestions and complaints. Many GP surgeries display information which is not only useful to patients but also to their carers or support groups; advice on looking after someone with chronic illness; and specific services offered by the practice, such as counselling. Similarly, for community pharmacists, providing a practice leaflet is one of the conditions for receipt of the professional allowance.

4.8 The NHS Executive is working with various Health Authorities and GPs to identify best practice in disseminating information to patients and the public which would enable them to choose the GP who is most suitable to their needs. This will cover both what information the public wishes to know about choosing their GP practice, and also suggest ways in which this information can most usefully and easily be published in an accessible and easy to understand format. The results will inform the contents of practice leaflets and charters as well as Health Authority arrangements for providing information about primary care providers.

4.9 The National Pharmaceutical Association's *Ask Your Pharmacist* campaign which has been running for some years is designed to raise public awareness about making better use of the skills of local pharmacists. For example, as first port of call when minor illness strikes, the pharmacist can advise on the appropriate treatment or course of action. Many Health Authorities, GPs, pharmacists and primary care teams are continuing to work in partnership to promote these messages.

4.10 There is already a well established freephone National Health Information Service which can provide callers with advice on local services, local waiting times, Patient's Charter and information on conditions and treatments, including support and voluntary organizations. In addition, following the Chief Medical Officer's review of emergency care outside hospital - *Developing Emergency Services in the Community* - the Government is considering piloting a national helpline which will promote more appropriate and effective use of NHS services by offering callers advice on how to get care in an emergency and what to do when faced with unexpected health crises. This reflects work with patient groups - both through their membership of the Government's review group and through focus groups - which revealed a desire to be able to cope responsibly with their own personal emergencies as well as those involving others.

4.11 Community Health Councils (CHCs) have a well-established role in providing information and advice on health and related issues to the public. Health Authorities are already required to work closely with CHCs in developing local health strategies. CHCs' knowledge of local people's views and satisfaction with services can also be of direct help to primary care professionals in improving the range and quality of services.

Improving information about appropriate use of services

4.12 Increasingly, developments under the Patient's Charter have included messages not only about patients' rights and the standards of service they can expect but also how patients themselves can help local NHS services run more effectively.

4.13 This has been reflected in turn in the way local practice charters have developed. These often suggest ways in which patients can help a practice deliver its services more effectively, for example, the most appropriate person to approach within the primary care team, what to do if an appointment has to be cancelled and when to call a doctor at night.

4.14 The *Doctor/Patient Partnership* campaign launched jointly by the Department and the British Medical Association aims to raise people's awareness about the importance of using family doctor services responsibly and to encourage people to take appropriate responsibility for their own health. It informs people of the alternatives to visiting the surgery or a home visit and highlights how these can benefit patients as well as doctors. Following the national media campaign, a public information film has been developed. Health authorities are also working with primary care professionals and patient groups to develop customised campaigns.

4.15 The Royal College of General Practitioners, supported by the Department, is developing, in consultation with patients, a number of patient leaflets which address the importance of patients' responsibilities to the NHS, how to deal with minor ailments and how to get the most from pharmacists. Similar initiatives, particularly on selfhelp and the treatment of common conditions, are very much part of local developments and are to be encouraged. The Department is also discussing with interested voluntary organisations how the benefits of regular sight tests and eye examinations might be better publicised.

4.16 The Government believes this is an important area of work but the evidence suggests that it is best pursued locally as these campaigns are the most effective. Accordingly, the Government expects Health Authorities to take forward work in this area. Health Authorities were advised that the level of general allocations for 1996/97 took account of the need for patient publicity campaigns to support the out-of-hours agreement and were asked to set aside £20,000 specifically to fund these local campaigns. For 1997-98, the resources allocated to Health Authorities will enable them to spend £30,000 for patient education campaigns.

Spreading and sustaining good practice

4.17 Although responsibility for taking forward further work on patient information primarily lies with Health Authorities in partnership with health care professionals, patients and their carers, there is a role for others to support local activity.

4.18 *The professions.* Earlier paragraphs outlined the continuing work of health care professions. The RCGP is developing patient information leaflets. The BMA continues to encourage and fully support activity on the doctor-patient partnership campaign. The National Pharmaceutical Association continues its campaign on the role of the local pharmacist. The Government welcomes and endorses these activities.

4.19 *Health Information Resource Centre.* Many organisations, groups and individuals within or related to the NHS produce patient information in a variety of forms - leaflets, booklets, computer software, videos, multi-media etc. Whilst this is to be encouraged, there is a huge amount of duplication in terms of time, effort and product, particularly at the level of individual NHS Trusts and Health Authorities. To help improve the quality of patient information and to help reduce wasted resources, the NHS Executive is establishing a Health Information Resource Centre which is expected to begin operating officially by April 1997. The

Centre's objective will be to act as a source of expertise and knowledge for the NHS and patient representative groups on all aspects of patient information with the aim of improving the NHS's capability, competence and capacity to provide good, evidence based patient information.

4.20 *The National Primary Care Research and Development Centre.* The Centre, funded through the Department's Policy Research Programme, has within its R&D programme work currently under way on factors influencing health care demand and decision making by patients. The Department of Health will discuss with the Centre how to do more to evaluate the effectiveness of patient information and disseminate the results widely to interested parties.

4.21 *Government.* As well as leading and supporting the development of better information in the ways outlined above, the Government is undertaking two further specific activities:

- *first,* following *A Service with Ambitions*, John Horam MP will lead an examination of the provision of information within the NHS, including information to the public;

- *second,* following the review of emergency services, the Department of Health has begun discussions with other Government Departments, particularly the Department for Education and Employment, about a longer term public education campaign. The aim will be to provide people, particularly children throughout their formal education, with basic health care advice and first-aid knowledge ensuring they have the confidence to deal with minor illnesses and injurisies and giving them at least a basic knowledge to make informed decisions.

Both will have significant impacts on primary care.

PATIENT AND CARER INVOLVEMENT AND CHOICE

Summary of Proposals

- Research on effectiveness of patient information in primary care (4.8 - 4.20)
- Department of Health/RCGP work on public advice on self help for common conditions (4.15)
- £30,000 included in each Health Authority's allocation for local public education campaigns (4.16)
- Health Information Resource Centre to start April 1997 to support the NHS locally and patient representative groups in improving quality of patient information (4.19)
- An Examination of the provision of information within the NHS, including information to patients, as part of the work programme for *A Service with Ambitions* (4.21)
- Work on longer term public education campaign to follow up review of emergency services (4.21)

Chapter 5

DISTRIBUTION AND USE OF RESOURCES

Introduction

5.1 Significant resources go into primary care. Total spending on primary care (including community health services) is around £12.45 billion. This represents over 36% of total NHS spending. If primary care is to continue to make a growing contribution to health care it needs to get a fair share of overall NHS resources. It must also make good use of available resources. Three important issues have emerged during the debate:

- a fairer distribution of resources across the country;
- the balance of resources between primary and secondary care; and
- greater flexibility in the use of resources locally.

5.2 These issues are not new. Inequities in the distribution of primary care resources have always existed. So too have barriers to the flexible use of resources across primary and secondary care. The Government is determined to tackle these long-standing problems. But change will need to be planned and managed carefully. For example, the move towards more equitable arrangements could put at risk existing services if it is taken forward too quickly.

5.3 A strong message from the primary care debate - not least from primary care professionals themselves - has been that we need to develop primary and secondary care in complementary ways. The Government shares this view.

5.4 Two points are important here:

- *first,* a well resourced primary care service is of direct benefit to patients and it can also help other parts of the NHS work better. Investments in primary care can help secondary care to work more efficiently;
- *second,* partnership between those in primary and secondary care is essential to ensure that service change is in the interests of patients and that it is managed in a way that takes account of the pressures on the different parts of the health and social care systems. Where there are appropriate shifts from one sector to the other, these should be properly resourced taking account of the effect on services overall. We return to this point later.

Fairer Resource Distribution

5.5 Patients' experience of primary care varies widely. A service striving for fairness must ensure that the range and quality of services does not vary significantly across the country or between patient groups. This calls for a fair distribution of resources.

5.6 Funds for some aspects of primary care are distributed less fairly than for other health budgets. In General Medical Services (GMS), resources have tended to follow GPs and GPs themselves are not distributed entirely equitably in relation to population needs. Distribution of funding of community health services has also taken less account of need than for hospital services and has not kept pace with shifts in workload as ways of delivering services have changed - particularly in relation to people with long term health needs.

5.7 To address these issues we have to improve the way we measure need in primary and community health care. We have to allocate resources in line with need. And we have to ensure that - once allocated - those resources are used effectively to meet those needs. Action is needed at national and local level.

5.8 Measures of need for community health services were historically much less developed than for hospital services. Work has been underway to address this and new indicators of need for community health services are now available. Work has also been under way on a measure of need to inform the allocation of GMS cash-limited funds which are used mainly to help GPs meet the cost of staff, premises and computers. The Government is committed to moving towards a system in which cash-limited funds for general medical and community health services better reflect the health needs of local populations. It therefore intends that in 1997/98 the allocation of these funds to Health Authorities will be based, among other things, on new improved indices of need. This will not result in radical changes overnight in the allocation of resources. The move toward a more equitable distribution of resources will be paced over a number of years. This process will be informed by continuing work further to refine measures of need and to ensure that resource allocation takes account of local variations in the costs of services.

5.9 Work is also continuing on developing measures of need for prescribing expenditure. Following a review in 1995, resources to Health Authorities are now allocated with reference to population weighted for age, sex and a measure of morbidity and social deprivation. Further research is planned on developing benchmarks for equitable allocation to GP practices.

5.10 The bulk of GMS resources - some three quarters - are not cash-limited nor at the discretion of Health Authorities. They are paid to GPs as fees and allowances to which they are entitled under their terms of service. Where resources go depends largely on where GPs practice, how many patients they have and what services they provide. The distribution of GPs is skewed with the number of GPs per head of population varying across the country. In some Health Authority areas there are over a third more GPs per head of population than in other areas. In some parts of the country expenditure is almost two thirds higher than elsewhere. The Medical Practices Committee (MPC) is responsible for the even distribution of GPs throughout England and Wales but this is through negative direction - preventing GPs from practising in areas which are already adequately doctored or over-doctored. And whilst this has helped to ensure that everybody has access to a family doctor, the ease of access and quality of services offered can vary from place to place.

5.11 The Government believes that a more equitable distribution of general medical services could in part be achieved through careful local planning by Health Authorities which takes full account of the needs of the populations they serve and the work implications for staff providing those services. Health Authorities have already started to undertake local workforce planning for general medical services which will help to inform financial decisions and lead to a better understanding of workforce issues. They will need to work closely with the MPC whose decisions will be informed by the plans.

5.12 Health Authorities have a key part to play in helping to bring about a fairer distribution of resources at local level. Many have made good progress in this area, working in partnership with practices to determine ways of allocating cash-limited GMS funds, fundholder budgets and indicative budgets to GP commissioning groups. Some Health Authorities are exploring approaches which take greater account of people's needs in the allocation of such budgets and in the deployment of GMS cash-limited funds. Such initiatives should be encouraged provided they are developed and implemented in partnership with practices. Chapter 7 gives details of a new development challenge fund which can be used to help to support these initiatives.

5.13 There is also scope for a more effective distribution of the pharmacy workforce resource overall. The Government will follow with interest the Royal Pharmaceutical Society of Great Britain's re-examination of what would constitute a rational distribution of community pharmacies and their intention to discuss skill mix issues with other pharmaceutical bodies and employers. Given the increasing opportunities for pharmacists' involvement out of the pharmacy setting, these developments are important.

Effective Use of Resources

5.14 Increasing the resources available for primary care and making resource distribution fairer do not of themselves guarantee a fairer or better service provision. Fairer and better services also depend on how those resources are used - whether they are spent on services at all, whether they are the right services, whether the services are provided cost-effectively and are clinically effective. It also requires collaboration between primary care professionals and Health Authorities in determining the best use of resources locally. Many of the initiatives outlined in this document are aimed at enabling resources to be used more effectively.

5.15 However, specific steps need to be taken to test the overall effectiveness of resource use. The Government therefore intends to consult on a package of indicators to help assess the effectiveness of general medical services in each Health Authority as a whole. The indicators will be piloted in 1997/98 with a view to their being implemented generally in 1998/99.

5.16 The Government will also consider ways in which a more effective use of general medical services resources can be encouraged, particularly in inner city areas. For example, at present GPs with patients from deprived areas on their lists receive additional payments to reflect their workload. The Government will discuss with the profession how such resources could be better targeted to encourage improvements in the range and quality of services provided.

5.17 The Government will make available to Health Authorities in England funds for selected schemes to improve the availability of General Dental services in certain areas. These schemes will build on experience from the 1996/97 access fund in enabling Health Authorities to devise schemes that are most cost effective in meeting local needs. Priority will be given to schemes most likely to have a direct and lasting impact on the availability of NHS dentistry and which offer best value for money. Schemes will be evaluated.

5.18 Comments made during the primary care debate suggested that aspects of the present remuneration structure for community pharmacy lacked incentives for encouraging service development and the effective use of pharmacists' skills. For example, the current structure of fees and allowances placed more emphasis on the number of items dispensed than assuring the effective care of patients. This theme was echoed in the pharmacy profession's own agenda setting exercise, *Pharmacy In a New Age*. This too is an issue the Government wishes to pursue. Alongside the Royal Pharmaceutical Society of Great Britain's proposed

examination of alternative remuneration structures the Government will discuss with the profession's representatives how the remuneration system can best fit future needs.

Balance of resources

5.19 If primary care is to develop it needs to secure an appropriate share of NHS resources. This requires getting the balance of resources right between primary and secondary care. Getting this balance right is a major issue for primary care staff who are concerned about taking on extra tasks on top of their existing workload. Equally, hospital staff, themselves facing significant workload pressures, need to be assured that a change in the balance will not undermine their ability to provide an effective service. Local authorities need to be assured that changes in the NHS do not present them with unexpected new or different work.

5.20 Health Authorities have a key role to play in ensuring such concerns are taken into account. They are responsible for developing local health strategy across the range of health care. To do this they need to view the resources available in the round, promote a discussion locally about how services should develop in future, how they will be funded and how any changes will be managed. GP practices involved in total purchasing, fundholding and commissioning groups are well placed to work in partnership with Health Authorities in discussions with hospital and community staff. The main requirements are to ensure that all parties - including local authorities - are involved from an early stage in discussions about service change and that plans are agreed to manage any transfer of work and resources.

5.21 The Government wants to foster greater partnership between primary and secondary care. It recognises that, even where local agreement is reached to move services into a primary care setting, it can be difficult to release resources from secondary care quickly.

5.22 Accordingly, the Government has decided that a proportion of the growth funds available to Health Authorities for Hospital and Community Health Services (HCHS) should be used for the further development of primary and community health services. The Government expects each Health Authority to devote at least 0.15% (£32 million nationally) of growth funds within HCHS in 1997/98 to these services. Health Authorities should secure the support of GPs locally in deciding how best to use these funds, using the mechanisms which they have established to discuss purchasing decisions. Both fundholding and non-fundholding GPs need to be involved in this process.

5.23 The Government expect these funds to be targeted on services which lie at the boundary of primary and secondary care. Its priorities for the use of these funds are:

- specialist medical, nursing and therapist support to people in residential care or nursing homes, or in their own homes for example on assessment, rehabilitation and continence; or support for high dependency care;

- mental health, for example extending service provision outside normal hours, a mental health key worker attached to one or more general practices, or an outreach worker;

- further development of shared care services for drug misusers for example through additional support for GPs and primary health care teams such as liaison workers, regular back-up in clinics and training. Health Authorities should discuss their proposals in this area with local Drug Action Teams.

5.24 These priorities should be given first consideration. However, the Government recognises that locally there may be more pressing priorities for the use of these funds. If it is agreed locally by Health Authorities and GPs that this is the case then the funds may be spent on the most appropriate priority for the area. The key point is that investment will be driven largely by the needs of patients for primary and community health services.

Flexibility

5.25 A number of recent developments - including the creation of new Health Authorities, total purchasing, fundholding and GP commissioning - have encouraged a more flexible use of resources. But the existing legal framework can act as a barrier to progress. Legal constraints on the funding arrangements for GPs, pharmacists and optometrists give Health Authorities little flexibility and are seen as increasingly artificial and unhelpful by professionals and managers alike.

5.26 The White Paper *Primary Care: The Future - Choice and Opportunity* and the NHS (Primary Care) Bill respond directly to calls for greater local flexibility in the use of resources so that services can be better tailored to the needs of local people and the aspirations of those who work within them. Subject to Parliament, the new legislation will allow greater flexibility in the use of NHS resources locally.

It will be possible to pilot on a voluntary basis a number of ideas suggested by primary care professionals. These include:

- local contracts with GPs to develop specific areas of general medical services over and above that required under the national contract such as contracts to provide care of increased quality to patients with severe mental illness or learning disability;

- piloting locally commissioned dental services;

- practice based contracts embracing all professionals thus opening new possibilities for development of skill-mix for example nurse led services for vulnerable groups such as homeless people;

- unified budgets at the level of the practice for general medical service, hospital and community health services and prescribing. This would be a further development of fundholding but offering scope for more integrated, efficient and better services for patients.

5.27 In addition, local contracts for community pharmacists will allow resources to be better targeted towards local needs

5.28 Some further flexibility is also possible under existing legislation. Concern has often been expressed that the arrangements for funding medicines can often perversely influence prescribing behaviour leading to inappropriate use of resources and accusations of "cost shifting". The Department therefore proposes to pilot arrangements to allow integrated budgets, for particular drugs commonly used, across the primary and secondary care sectors at Health Authority level to ensure the right incentives both for the appropriate care of patients and for the use of resources.

5.29 Greater flexibility is also needed to improve delivery of care across health and social services boundaries. Health Authorities and local authorities are already doing good work on this front. The further involvement of fundholding and commissioning groups could bring added benefits here. There are already several good examples of local collaboration involving "side-by-side" budgets for health and social services, often held at practice level.

PRIMARY CARE RESOURCES

Summary of Proposals

- An extra £65 million in GMS cash-limited funds (6.7% real terms growth) for 1997/98 (1.19)
- More equitable allocation of cash-limited funds for GMS and community health services funds in 1997/98 (5.8)
- Development of benchmarks for allocation of prescribing resources to GP practices (5.9)
- Pilots of GMS effectiveness indicators at Health Authority level in 1997/98 with a view to implementation in 1998/99 (5.15)
- Consultation on ways of improving targeting of GMS resources in inner cities (5.16)
- Schemes to improve availability of general dental services (5.17)
- £32 million new funds for Health Authorities in 1997/98 specifically for community and primary care service improvements (5.22)
- Pilots of locally commissioned dental services (5.26)
- Pilots of integrated hospital and primary care prescribing budgets for selected medicines (5.26)

Chapter 6

WORKFORCE AND PREMISES

Introduction

6.1 Like any service, primary care needs a well-trained, skilled and motivated workforce. It needs to recuit staff in the right numbers to work in the right places. And the workforce needs to have adequate premises from which to provide a full range of high quality services.

Workforce

6.2 The number of staff in all the professions involved in primary care has grown significantly in the past decade. Overall, the current numbers of professional and other staff working in primary care are adequate and the short term prospects for sustaining them are also reasonable. However, there are difficulties in some areas as well as signs of future pressure in others arising from the changing nature of the workforce and its aspirations. These points were fully explored during the recent debate and in *Primary Care: The Future.* Action is needed now to secure the future needs of the service through a well motivated and adequate work force.

6.3 There is no one single action which will ensure that the necessary workforce is available. A range of measures is needed. And they are not confined to the traditional measures related directly to recruitment and retention. The Government's strategy has four main components:

- a sound understanding of the workforce and a more coherent approach to planning;
- raising the profile of primary care and ensuring that it is an attractive and professionally satisfying place in which to work;
- developing new employment opportunities to ensure that the needs and aspirations of a changing workforce can be properly met;
- specific measures to ensure that there are as few structural barriers as possible to recruitment to primary care.

Planning

6.4 Primary care workforce requirements need to be addressed coherently. The starting point for this should be an understanding of current services and the workforce providing them. Proposals for service development to meet local needs then need to be considered against the workforce implications. It will be increasingly important to look at

the capacity of the primary care workforce across the board rather than simply profession by profession. The aim should be to develop a clear view of how multi-disciplinary working and use of skill mix can support the development of services. Primary care workforce requirements also have to be assessed and balanced with those in secondary care.

6.5 The new arrangements for local general medical services workforce planning introduced earlier this year are a step in this direction. Health Authorities are now responsible for developing a plan over the medium term for the general medical services workforce in their area. These plans will increasingly address educational and development needs for medical and non-medical staff. It is essential that they are put together in consultation with the profession locally. These views will be fed into local education consortia and the Medical Practices Committee so that they are better able to reflect local needs when carrying out their functions. The Government will encourage Health Authorities to build on these arrangements to embrace the wider primary care workforce and to take account of the need for integrated workforce planning across primary and secondary care. This will help to ensure that both sectors get their fair share of young doctors and that decisions taken nationally on the NHS workforce are consistent with the needs of patients locally.

Developing Primary Care

6.6 The development of primary care will continue to bring benefits to patients and offer the potential for more satisfying careers for those who work within it. It will increasingly provide considerable opportunity for career development for both professional and non professional staff. For professionals, there will be scope to develop their clinical practice further and more satisfyingly. Action has already successfully been taken sucessfully in the past year through the out-of-hours arrangements, the Patients not Paper initiative and the removal of much of the bureaucracy surrounding health promotion in general practice to address some major areas causing dissatisfaction and unnecessary extra work. More generally, the measures set out in this document should make a major contribution towards ensuring that primary care is a more attractive and fulfilling working environment. The proposals in chapters 2 and 3, in particular, -to promote better multi-professional partnerships, professional education and training and research opportunities - respond to points raised by primary care professionals during the recent debate and will make a career in primary care a more satisfying option.

New employment opportunities

6.7 The Government believes more flexible employment opportunities are required to meet the changing needs and aspirations of the primary care workforce. This has been a recurring message throughout the debate on primary care. The legislation proposed in *Primary Care: The Future - Choice and Opportunity* will open new possibilities to tailor arrangements better to suit the needs of primary care professionals as well as patients. A salaried option for GPs and dentists, for example, could be attractive to professionals seeking part-time working or more flexible careers and for those who are reluctant or unable to make a heavy personal investment in practice premises. Practice-based contracts would give practices additional flexibilities to manage all their resources and encourage the development of team-working and more fulfilling careers for non-medical staff. Locally agreed additions to existing contracts for GPs would allow Health Authorities to provide incentives for practices to develop services over and above the national contract, thus creating greater scope to reward and motivate primary care professionals.

6.8 In addition to the legislation, the Government intends to introduce further measures to improve employment opportunities in primary care. Specifically:

- to improve the GP retainer scheme. The Government intends, through consultation with the profession, to increase the number of retainer sessions which may be remunerated under the Statement of Fees and Allowances to allow greater opportunity for GPs to keep in touch with practice and maintain their skills during career breaks, for example to raise a family. Greater flexibility in the retainer scheme will be complemented by the scope for re-training. Six-months refresher courses will continue to be available to doctors returning from a career break to ensure that they have the skills and confidence to move easily back into the workforce;

- to discuss with the dental profession development of the Keeping In Touch Scheme (KITS). There has been a gradual increase in the proportion of newly qualified women dentists. Such changes in the structure of the workforce and gender balance have potential implications for service provision;

- a new scheme to allow Health Authorities to meet all or part of the costs of a practice (or more than one practice working together) employing a full or part-time doctor. This responds to the growing demand from practitioners (particularly newly qualified GPs who do not wish to enter partnership yet) for service options other than those of partner, assistant or locum. It will also give practices and Health Authorities additional flexibility to address local service needs.

Removing barriers

6.9 The final element of the strategy is to ensure that there are as few structural barriers as possible to recruitment into primary care. A major barrier which has been identified for some time is the lack of access of practice staff to the NHS Pension Scheme. This has been a longstanding concern for practice staff and GPs. Practice staff are a vital part of primary care teams. They make a significant contribution to the NHS. Their exclusion from the NHS Pension Scheme is now clearly anomalous. The Government therefore intends to open the NHS Pension Scheme to staff employed by GPs. The new arrangements will take effect from September 1997. The detail of how the Government intends to introduce these arrangements will be discussed with the profession's representatives. The increase in GMS cash limited funds in the Budget will help to support the costs for employers of opening the NHS Pension Scheme.

6.10 The Government also believes that the NHS should have access to the largest pool of appropriately qualified and experienced doctors to work in general practice. Overseas doctors (those from outside the European Economic Area) are an important source of supply for NHS hospital services. However, the current Immigration Rules limit the ability of general practice to benefit from the contribution of overseas doctors. A number of people within the profession expressed the view during the recent debate that these restrictions should be eased or lifted. The Government wishes to consider these views in greater detail, and in particular to examine carefully how the proposal could have a positive impact on the quality of service. It therefore proposes to consult the profession and others on this.

Premises

6.11 Apart from the contribution of the primary care workforce, the quality and range of services offered will depend on the state of primary care premises and how well they are equipped. The Government's aims are to ensure that all premises are adequate for the provision of personal,

hygienic care and where appropriate to enable them to accommodate a wider range of services and staff. The primary care debate has helped to clarify the way forward on the type of premises needed and how their development can be encouraged.

6.12 First, premises developments should be led by service needs. The need to allow for diversity follows from this. No single model of premises is likely to meet future needs in primary care. Many GPs have already developed a wide range of services in the community around general practice premises. Others will also be able and willing to do so. However, in other cases it will make more sense to develop services on alternative community-based sites to provide the extra space needed. There is significant support for some larger developments such as "resource centres" providing a wide range of health and social care, and "cottage hospital" facilities providing outpatient and rehabilitation services as well as general medical services. But, as well as these larger developments, smaller premises will continue to be needed so as to ensure easy access for patients. The Government's intention is to enable a range of premises to continue to be developed to reflect differing local needs and circumstances.

6.13 Secondly, a mix of incentives and funding arrangements are likely to be required to meet these needs and the varying aspirations of primary care professionals. The development of GP premises has for several years been based on a mixed system of private and public ownership and funding, with strong incentives for GP ownership. Capital for premises has, to a large extent, been raised privately by GPs or private landlords, with a range of support from the NHS to help GPs meet the revenue costs of owner occupation and renting. This system of funding has helped to provide generally good quality primary care premises. It gives the people who know most about the type of primary care services needed, the primary care professionals themselves, a strong influence in how services are shaped. However, there is a need to take better account of GPs' differing aspirations. Some GPs will want to own or co-own premises; others (perhaps an increasing number) will prefer to rent.

6.14 The Government believes that the development of primary care premises should continue to be based on partnership between the NHS and GPs, with capital raised in the private sector. Health Authorities and GPs already have a range of tools available to support the development of primary care premises. However, an important message during the primary care debate was the need to provide further flexibility in this area.

The Government therefore proposes to introduce the following measures to increase the range of options open to GPs and Health Authorities:

- to introduce new cost-rent schedules for GP premises. The existing schedules - which define the optimum range and size of premises for cost reimbursement - are now twenty five years old. They do not reflect the needs of modern primary care. The new arrangements will allow GPs greater flexibility in developing premises to accommodate a wider range of services. The new schedules will be introduced in 1997 following consultation with the profession;

- to amend the GPs' Statement of Fees and Allowances to enable Health Authorities to use loans or grants to help GPs buy themselves out of leases on sub-standard premises, on the condition that they agree to invest in improved premises. This could in the long run save committing NHS funds to the upkeep of inadequate premises. It would provide the incentive, for example, to single-handed GPs who are in inadequate property to move out and share new premises that meet the needs of their patients;

- to encourage the development of health centres. Some 25% of GPs practice from health centres, most of which are owned by NHS Community Trusts. The Government will introduce new funding arrangements from April 1997 which will facilitate the maintenance, repair and improvement of health centre premises;

- to encourage through the Private Finance Initiative the further use of private sector investment in GP premises. Some GPs are reluctant to become owner-occupiers of their premises. The private sector can play a positive role by giving them access to high quality premises, possibly shared with other primary care professionals to enhance the co-ordination of services. It could, in particular, open new opportunities for improving health centres. Guidance will be issued to the service to clarify the possibilities offered by private investment in primary care. Health Authorities and NHS Trusts will have a key role in partnership with primary care professionals in exploring the scope for private investment, establishing value for money and bringing schemes to fruition.

6.15 Within this framework, fundholder savings are a relatively new source of funds for premises development. As the fundholding scheme itself has expanded, so too have the overall levels of savings and the range of premises improvements for which it would be sensible for practices to use them. The Government therefore plans to introduce new flexibilities into the use of fundholder savings for premises development while, at the same time, bringing their use into line with other sources of support for primary care premises. The current rules governing the use of fundholder savings can provide a perverse incentive to develop

existing premises when what may really be required is a new building or a move to a new site. Accordingly the Government plans to amend the fundholding regulations to permit the purchase of land or new buildings, subject to safeguards regarding benefit for patients and value for money. This change will be part of wider proposals which the Government plans to bring forward shortly governing the use of savings to develop premises and which follow discussion with Health Authorities, the National Association of Fundholding Practices and other professional bodies. The proposed changes would establish authorising arrangements to ensure that savings from the funds are used to meet service needs in ways which secure value for money and relate to the size of the development.

6.16 The overall effect of this package of measures should be to generate a continuing momentum for premises improvements linked closely to service needs and reflecting the circumstances of practitioners. The proposed new legislation will provide a further boost by allowing a more flexible use of resources for combined general medical services and hospital and community health service purposes and the tailoring of the provisions in the Statement of Fees and Allowances ("Red Book") to local circumstances.

WORKFORCE AND PREMISES

Summary of Proposals

Workforce

- Better primary care workforce planning (6.5)
- New employment and contract options in NHS (Primary Care) Bill (6.7)
- New salaried doctors scheme in addition to *Choice and Opportunity* proposals (6.7)
- Improved GP retainer scheme and access to re-training (6.8)
- Review of Keeping in Touch scheme for dentists (6.8)
- NHS Pensions Scheme open to practice staff from September 1997 (6.9)
- Consultation on easing restrictions on overseas doctors entering general practice (6.10)

Premises

- New cost rent schedules to allow funding for wider range and size of premises (6.14)
- Loans/grants to help GPs move out of sub-standard premises (6.14)
- New arrangements to encourage the development of health centres (6.14)
- Encouragement through the Private Finance Initiative of further use of private investment for premises development (6.14)
- New arrangements governing use of GP fundholder savings for premises (6.15)

Chapter 7

BETTER ORGANISATION

Introduction

7.1 Better organisation in primary care can reduce burdens on professionals and lead to better services for patients. Three areas for further development have been identified during the debate on primary care:

- linking practices together;
- management support for improved organisation; and
- developing and making better use of Information Technology.

Linking Practices Together

7.2 Bringing practices together, while maintaining their independence, offers significant benefits. It provides a way for primary care teams to share resources and broaden the range of services they can offer to patients. It can also help primary care staff to develop their knowledge and skills through shared education, training, R&D and clinical audit. For example, a number of small practices may share the services of community mental health workers.

7.3 In some cases, the willingness to work together will be there, but practices will require assistance in getting the arrangements up and running. There is an important role here for Health Authorities, supported by Government where appropriate.

7.4 The development of GP co-operatives is a case in point. There has been a rapid growth in the last year in the number of GP co-operatives, fostered largely by the establishment of the out-of-hours development fund. Together, GPs and Health Authorities have used the fund to good effect. GPs are co-operating together to provide out-of-hours services, helping them to balance the demands of work and home life, and make more efficient use of their time. Patients have access in emergencies to local GPs with knowledge and experience of local services. And GPs are better able to continue to provide a high quality of care for their patients both during the day and at night. Some GP co-operatives are collaborating with ambulance services to improve out-of-hours availability through provision of communication links and transport.

7.5 The Government recognises the impact that the out-of hours development fund has had on these services. The fund has therefore now been included as part of health authority's baseline expenditure to ensure that

earmarked funds for this service continue to be available on a more permanent basis. The fund for 1997-98 for England has been increased to £39.4 million.

7.6 Health Authorities, are already looking to encourage and facilitate linked arrangements where appropriate when agreeing future developments with primary care professionals. The Government expects this to continue and to be further developed. Special initiatives taken in the London Initiatives Zone (LIZ) have shown how bringing practices together for educational purposes can also have service benefits. The principles could be extended elsewhere particularly using the flexibilities proposed for local additions to existing contracts in *Choice and Opportunity*. Similarly the new premises flexibilities proposed will make it easier to develop existing or new shared facilities. Health Authorities should consider the possibilities for non-medical professionals, such as counsellors, physiotherapists and chiropodists, who are attached to a particular GP practice, to be shared between a number of practices in the locality. They can also help set up local networks which enable primary care professionals and managers to get together and share ideas.

7.7 Equally important is the involvement of primary care in purchasing and commissioning. Here too there can be benefits in practices grouping together voluntarily to reduce bureaucracy and to agree a common approach to developing services for local communities. Building on the success of fundholding, total purchasing and commissioning groups, the Government proposes to pilot further developments in a number of sites where GP practices (both fundholding and non-fundholding) wish to join in partnership arrangements with Health Authorities to improve the planning and purchasing of services and the use of resources for local people. These GP locality pilots will need to have clear shared objectives for improving services for patients and agreements about managing overall levels of resources, including prescribing and contingencies. They will be evaluated in a similar way to the existing total purchasing and fundholding pilots. Applications for pilot schemes will shortly be invited through NHS Executive Regional Offices.

Management Support

7.8 Modern primary care faces complex and changing demands. Management skills and organisational development are increasingly important in helping those who work in primary care to cope with these demands. Better management and organisation can reduce the burdens on primary care professionals and lead to better services for patients.

7.9 Practice managers are now widely recognised as key members of primary care teams. They make a valuable contribution not only through the day-to-day management of increasingly complex organisations but

also as facilitators of change and innovation. They have often played an important role, for example, in developing and managing multifunds, in bringing practices together to share skills and resources, and in ensuring effective links with Health Authorities and NHS Trusts.

7.10 Health Authorities have an important supportive role here. In developing local health care strategy they need to discuss with practices what their organisational and management development needs are and ways in which these might be addressed, for example through targeted training funds for practice staff. The proposals in Chapters 2 and 6 will provide new opportunities for the development of all members of the primary health care team. National professional and managerial organizations can play a similar role.

7.11 The Government intends to support local efforts in this area by launching a "helping practices to help themselves" initiative to disseminate examples of good practice in primary care organisational and management development. Specific actions which have already been shown to produce benefits include: establishing local practice manager networks with Health Authority links to ensure a healthy exchange of information and ideas, and to provide mutual support; personal development plans for practice staff; and establishing a single management structure for primary care teams.

7.12 The Government also intends to develop, in discussion with Health Authorities and primary care professionals, indicators to help Health Authorities improve their management support for people working in primary care. The Government will discuss with national organisations representing professionals and managers ways in which primary care professionals and staff locally might be supported in developing management skills, for example through the development of standards and competencies and education and training opportunities.

7.13 The Government also intends to launch a development challenge fund of £2 million over the next 15 months to support local organizations - Health Authorities, NHS Trusts, and primary care teams - in taking foward innovative work under each of the key chapter themes in this White Paper. The fund is designed to give local organizations added headroom to take forward initiatives in the short term. The intention is to make developments happen locally in specified areas. Bids for projects will be invited shortly and will be funded 75% by the NHS Executive and 25% locally.

Information Technology

7.14 The Government wants to encourage primary care staff to make greater use of IT developments which are capable of supporting better care. IT in primary care offers many potential benefits to patients:

- **better prevention**: IT enables, for example, more efficient call and recall for examination, screening and immunisation helping to prevent disease or to deliver early treatment. It also gives professionals access to more comprehensive information to monitor the health needs of the local population;

- **better care:** It is now possible for patient referrals, appointments and test results to be processed quickly and efficiently through electronic links between practices and hospitals. Such links are already available in some places. Work is also underway to enable the electronic transfer of medical records between general practices. Primary care professionals can make better clinical decisions supported by electronic access to the latest knowledge bases, decision support systems and training material. Developments in telemedicine offer the potential to bring expert services to the practice of the patient's home removing the need for patients to travel to hospital;

- **better communications between professionals:** IT can help professionals collaborate with each other and improve the co-ordination of care. The electronic transfer of clinical records and information opens the way, subject to confidentiality safeguards, for better communication between GPs and other primary care professionals and between primary care, secondary care and social services.

- **less bureaucracy:** Electronic processing of patient registration and items of service is already reducing administration costs in Health Authorities and ensuring quick, accurate payments to primary care practitioners. Practices can benefit from more efficient management and maintenance of clinical records, including easier and more accurate data entry and retrieval procedures.

7.15 The Government's vision is of a primary care service where staff routinely use IT to deliver such benefits. We have already made good progress towards this vision. Major investment over the last few years has encouraged a dramatic spread of GP computing. Over 90% of practices are computerised. Virtually all community pharmacies are computerised and current activities by community pharmacists are well served by IT systems, although further developments may be needed in order to integrate and keep pace with developments elsewhere. Most GP practices are now linked electronically to Health Authorities for patient registration and increasingly the processing of item of service claims. Similar arrangements are being developed for optometric practices and the expansion of the Electronic Data Interchange (EDI) link between dental practices and the Dental Practice Board (DPB) has been equally successful. The essential elements of the infrastructure - the NHS-wide communications network and common information

standards - to enable primary care professionals to exchange information electronically with the wider NHS are now largely in place. In addition a Dental Internet, has also been launched by the Dental Practices Board which will provide a dedicated Internet Service for dentists and practice staff. The public pages should improve access to NHS dentistry and the professional and academic pages improve the quality of care dentists are able to offer.

7.16 The challenge now is to ensure that the clinical, as well as the administrative, benefits of IT are more fully exploited, particularly in general practice.

7.17 Important principles here are:

- **professionally-driven national standards**: It is widely accepted that the development of IT in general practice should be based on national standards to promote value for money. However, IT developments should not be imposed on primary care teams. Professional requirements should be the driving force for the future. The benefits of IT will only be fully realised if primary care professionals have confidence in the IT systems and in their own capacity to make use of them. This points to measures which give primary care professionals an effective say in shaping national strategy and in its implementation locally;

- **local partnership**: Local improvements in GP computing have rested on partnership between Health Authorities and primary care professionals. This should continue. Health Authorities will have a major enabling role - developing in partnership with GPs an agreed approach to implementing national IT strategy at local level, assisting with costs through reimbursement arrangements, and supporting and providing advice in planning, procuring and using systems.

7.18 To encourage the development and use of computing in general practice the Government proposes:

- to introduce greater incentives for GP computing systems to conform with national accreditation standards. From September 1997 reimbursement for new systems will only be available to GPs for systems which meet the standards set out in the national Requirements for Accreditation (RFA). This will ensure greater value for money and encourage the development of systems which can communicate with each other;

- to introduce a more open system for developing computing standards for general practice, with greater involvement of professionals and managers locally;

- to encourage the networking of GP systems with the wider NHS. The proposed changes to the accreditation system will provide a means for ensuring that investment in new systems is channelled at systems which can communicate electronically with other parts of the NHS. In addition, the Government will set up demonstrator sites to promote awareness and assist local planning elsewhere.

- to change statutory regulations, subject to consultation, to legitimise the computerisation of GP medical records. This will respond to requests from the profession and will allow practices to move to paperless systems if they wish.

7.19 The Government will also discuss with the dental profession alternative ways to support the development of computerisation in dental practice to replace the present EDI grant.

7.20 The Government also continues to support training and research to enable primary care fully to exploit the clinical benefits of new technologies. The Government is funding a 3-year research project (PRODIGY) to assess the value of decision support for GP prescribing, and its acceptability to GPs and their patients. The PRODIGY system will provide general guidance on the options for treating those conditions most commonly encountered in general medical practice, recommendations for prescribing or other treatment options, and access to comprehensive information on all available medicines. A decision will be taken at the end of the project, in autumn 1997, on whether to make the system widely available for use by GPs.

7.21 Aided by implementation of the national Information Management and Technology strategy, IT is already helping primary care teams to provide more effective and efficient care. The proposals set out here offer new opportunities for primary care professionals to use IT to improve patient care.

BETTER ORGANISATION

Summary of Proposals

- £39.4 million Out-of-Hours Development fund for 1997/98 and funds for this service to continue to be made available on more permanent basis (7.5)
- GP locality pilots (7.7)
- "Helping practices to help themselves" initiative (7.11)
- Performance management criteria for Health Authorities to improve support to primary care (7.12)
- £2 million primary care development challenge fund to support primary care teams, Health Authorities and NHS Trusts in taking forward innovative work in line with the White Paper themes (7.13)
- New accreditation requirements for GP computing (7.18)
- Incentives for GP practices to link to NHS network (7.18)
- New regulations to allow use of computerised medical records (7.18)
- Continued development of PRODIGY - decision support for GP prescribing project (7.20)

CONCLUSION

This White Paper, together with the proposed new legislation, sets out new means and opportunities to develop primary care. Taking advantage of these opportunities will require the commitment and action of various parties.

The Government proposes to consult the relevant professions to take forward the various changes which require action at national level.

Health Authorities should continue to encourage and support the development of primary care locally using the new flexibilities and initiatives to complement existing strategies. They should engage in discussions with primary care professionals about how best to take forward the various proposals locally for the benefit of patients and those who work in primary care.

Primary care professionals themselves will have a pivotal role in taking forward the new agenda. They should seize the opportunities on offer to initiate change and improvements to services.

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